Pediatric Evaluation and Management: Coding Quick Reference Card 2025

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Pediatric Office/Other Outpatient and Inpatient Evaluation and Management Services

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CPT LEVEL OF MDM

(This table applies to both office/other outpatient and inpatient E/M services. To report an MDM level, 2 of the 3 elements for that level must be met or exceeded.)

Number and Complexity of Problems Addressed	Amount and Complexity of Data Reviewed/Analyzed	Risk of Complications/ Morbidity or Mortality
Text	Text	Text
Minimal • 1+ self-limited or minor problem*	**Minimal or none**	**Minimal risk** of morbidity from additional diagnostic testing or treatment
Low • 2+ self-limited or minor problems*, or • 1+ stable, chronic illness, or • 1+ acute, uncomplicated illness or injury** **Examples/Presumptive Low Risk** • 1+ positive screen/flowsheet • 1+ acute, uncomplicated illness or injury requiring hospital observation/extended visit of care***	**Limited** (Must meet the requirements of at least 1 of the 2 categories) **Category 1:** Tests, documents, or independent historian(s) Any combination of 2 from the following: • Review of prior external note(s) from each unique source**** • Review of the result(s) of each unique test***** • Ordering of each unique test***** **Category 2:** Assessment requiring an independent historian(s)* (Refer to **Moderate** or **High** for independent interpretation of tests and discussion of management or test interpretation.)	**Low risk** of morbidity from additional diagnostic testing or treatment Examples only: • Physical therapy • OTC drug(s) (eg, aspirin, NSAIDs) • Minor surgery with no risk factors • Physical therapy • Occupational therapy
Moderate • 3+ chronic illnesses with mild exacerbation, progression, or side effects of treatment, or • 2+ stable chronic illnesses, or • 1 undiagnosed new problem with uncertain prognosis, or • 1+ acute illness w/ systemic symptoms, or • 1+ acute, complicated injury	**Moderate** (Must meet the requirements of at least 1 out of 3 categories) **Category 1:** Tests, documents, or independent historian(s)* Any combination of 3 from the following: • Review of prior external note(s) from each unique source**** • Review of the result(s) of each unique test***** • Ordering of each unique test***** • Assessment requiring an independent historian(s)*, or **Category 2:** Independent interpretation of tests • Independent interpretation of test performed by another physician/other QHP (not separately reported) and **Category 3:** Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other QHP/appropriate source (not separately reported)	**Moderate risk** of morbidity from additional diagnostic testing or treatment Examples only: • Prescription drug management • Decision regarding minor surgery w/ identified patient or procedural risk factors • Decision regarding elective major surgery w/o identified patient or procedural risk factors • Diagnosis or treatment significantly limited by social determinants of health
High • 4+ chronic illnesses, illnesses w/ severe exacerbation, progression, or side effects of treatment, or • 1 acute or 1 chronic illness or injury that poses a threat to life or bodily function	**Extensive** (Must meet the requirements of at least 2 out of 3 categories) **Category 1:** Tests, documents, or independent historian(s)* Any combination of 3 from the following: • Review of prior external note(s) from each unique source**** • Review of the result(s) of each unique test***** • Ordering of each unique test***** • Assessment requiring an independent historian(s)*, or **Category 2:** Independent interpretation of tests • Independent interpretation of test performed by another physician/other QHP (not separately reported) and **Category 3:** Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other QHP/appropriate source (not separately reported)	**High risk** of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery w/ identified patient or procedural risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of patient/family choice

* Most or definitive work since there may be a historian (adult, child, non-caregiver) who provides.

** Review of a test (chest film) performed by another physician/QHP is not "data from all three/assessing and testing" (with the exception of a test performed and reviewed during the same encounter) or a definitive and summarized source. Examples may include allergy, diarrhea, or a simple sprain.

*** Moderate (applicable rarely in the inpatient/observation setting)

**** Each unique test, order, or document may be counted in multiple (eg per order) ways. Each physician (or other qualified health care professional) or appropriate source may be counted.

***** Separately billed tests with modifier 59 (Distinct Procedural Service) may be counted separately. Ordering or deciding to perform a test or procedure is counted as an element. Performing a test or procedure is not counted as ordering a test or procedure. Ordering a test or procedure is not counted if it was performed by the patient because they are unable to provide a complete or reliable history (eg because of their developmental stage) or because a confounding history is suggested by the seemingly inconsistent or atypical symptoms.

† When a risk factor is present, symptoms and signs may need to be elicited or sought that are not necessarily volunteered by the patient. For example, a patient who reports smoking cigarettes may not be prompted to discuss symptoms of chronic bronchitis. Even though a chronic illness may not be treated or addressed at the encounter, it may require interval history, examination, and review of medications, or may affect the medical decision making of the encounter.

‡ Independent historian(s) are those who are not the patient, family member, or caregiver and who provide a substantial medically appropriate history and/or information beyond that obtained from the patient, family member, or caregiver. Examples include but are not limited to: parents of a newborn, foster parent, or caregiver of a child who is unable to provide a history; a teacher who is concerned about a child's behavior; a coach who is concerned about a child's performance; a case manager who is concerned about a child's adherence to a treatment plan; or a probation officer who is concerned about a child's behavior.

§ Independent interpretation of a test performed by another physician/other QHP is not separately reported if the service for the patient is part of the interpretation report that is documented and used for decision making. Examples include but are not limited to: chest x-ray images reviewed independently by the physician/other QHP and compared with the radiologist's report; and ECG tracings reviewed independently by the physician/other QHP and compared with the cardiologist's report.

‖ Discussion of a test that ordered by a QHP, consulted, or recommended in response to a consult. Does not apply if the physician or other QHP is reporting or has previously reported the service for the patient in terms of interpretation (even the documented test result was unaffected by the QHP's discussion with the patient). Examples include but are not limited to: discussion of a radiologist's report with the ordering physician; discussion of a pathology report with the surgeon who submitted the specimen; discussion of a cardiac catheterization report with the referring physician; discussion of a psychological test report with the referring physician.

¶ For therapeutic agents that have the potential to cause serious morbidity, a determination of risk of complications and/or morbidity and mortality of treatment options often requires an appreciation of the risks associated with the drug itself. A chart that is limited to a description of the medications prescribed, without any discussion of the underlying reasons for ordering the medications, is rarely sufficient documentation to support a medical decision of any complexity.

ACTIVITIES COUNTED TOWARD TIME

(Physician's/other QHP time includes the following activities, when performed:)

- Preparing to see/see the patient (eg reviewing test results)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate exam and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring to and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family or caregiver
- Care planning (care not separately reported)

Usually (document total time spent). Although start and stop times are encouraging, per AMA, reference to start time or the date of service is required. Documentation of the activities and support time throughout the day (and across multiple days) is required when counseling and/or coordination of care dominate (more than 50%) the service. (See examples next page.)

Office and Outpatient Consultation & NF Services

CPT Codes	Time, min	Problems Addressed	Data/Reviewed/ Analyzed	Risk	Level of MDM
New Patient					
➔ 99202/99	15 (also count for each additional 15 min)	1 self-limited or minor	Minimal or none	Minimal	SF
➔ 99203/99	30 (also count for each additional 15 min)	Low	Limited	Low	Low
➔ 99204/99	45 (also count for each additional 15 min)	Moderate	Moderate	Moderate	Moderate
➔ 99205/99	60 (also count for each additional 15 min)	High	Extensive	High	High
Established Patient					
99211/11	Text	Text	Text	Text	N/A
➔ 99212/12	10 (also count for each additional 15 min)	Minimal	Minimal or none	Minimal	SF
➔ 99213/13	20 (also count for each additional 15 min)	Low	Limited	Low	Low
➔ 99214/14	30 (also count for each additional 15 min)	Moderate	Moderate	Moderate	Moderate
➔ 99215/15	40 (also count for each additional 15 min)	High	Extensive	High	High

PROLONGED OFFICE/OTHER OUTPATIENT AND CONSULTATION E/M SERVICES

Refer to the "Prolonged Clinical Staff Time" code tables.

- Time codes: **99417**
- Report per 15 min of prolonged time.
- Add-on code (do not report solo), in addition to CPT codes 99205/99215, or 99233/99
- May be reported only when time was not billed to count for code selection.
- Accounts for all time spent on that calendar day (both direct face to face time w/ the patient and non-direct time spent on their services for that patient).

TOTAL TIMES SUPPORTING PROLONGED SERVICE CODES

Time, min	CPT Codes	Time, min	CPT Codes	Time, min	CPT Codes
New Patient		**Established Patient**		**Outpatient Consultations**	
<183	➔ 99205/99	<183	➔ 99215/15	<183	➔ 99233/99
183–197	➔ 99205/99 + ➔ 99417/1 × 1	183–197	➔ 99215/15 + ➔ 99417/1 × 1	183–197	➔ 99233/99 + ➔ 99417/1 × 1
198–212	➔ 99205/99 + ➔ 99417/1 × 2	198–212	➔ 99215/15 + ➔ 99417/1 × 2	198–212	➔ 99233/99 + ➔ 99417/1 × 2
≥213	➔ 99205/99 + ➔ 99417/1 × 3 (or use the new 99418 for 3 or more 15-min periods beyond the first hour)	≥213	➔ 99215/15 + ➔ 99417/1 × 3 (or use the new 99418 for 3 or more 15-min periods beyond the first hour)	≥198	➔ 99233/99 + ➔ 99417/1 × 2 (or use the new 99418 for 3 or more 15-min periods beyond the first hour)

PROLONGED CLINICAL STAFF TIME (OUTPATIENT SETTING)

Refer to the CPT Total Duration of Prolonged Services Table for guidelines on correct reporting of prolonged services.

- Report prolonged clinical staff services: **99415** and **99416** as additional to office or other outpatient E/M codes 99202–99215. May not be reported on the same day as **99417**.
- Count cadre/base face-to-face time between clinical staff and the patient/family or caregiver.
- Requires a minimum of 30 min of clinical staff time.
- May be reported for no more than 2 consecutive patients, and the time reported is the time devoted solely to a single patient.
- Time spent by the physician is not relevant or counted toward the total of clinical staff time of the CPT code reported for the physician's service.
- Time spent does not have to be 30 min beyond the time in the CPT service reported (eg, 99213/13 + reported clinical staff time does not require an 11–15 min beyond the time in 99213/13).

Abbreviations: CMS, Centers for Medicare & Medicaid Services; CPT, Current Procedural Terminology; E/M, evaluation and management; HCPCS, Healthcare Common Procedure Coding System; MDM, medical decision making; NF, nursing facility; QHP, qualified health care professional; SF, straightforward; min(s), minute(s); MD, doctor of medicine; DO, doctor of osteopathic medicine.

• = indicates a CPT code/guideline/descriptor change

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